

CLIENT CARE COORDINATION PLAN

Annual Cycle Month: (Due prior to the 1st day of the Month)
☐ Jan ☐ Feb ☐ Mar ☒ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Client Long Term Goals: (use client direct quote)

"I want to feel less anxious about every little thing that happens in my life"

Short-term Goals / Objectives: Must be SMART: Specific, Measurable/Quantifiable, Attainable within this year, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1

Effective Date: 4/20/12

Diminish anxiety symptoms as evidenced by client's GAD-7 score decreasing from 17 to a score below 10.

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: ☒ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other

Teaching and reinforcing active problem-solving skills in order to increase client's self-efficacy and stabilize their mood.

Client Involvement

Client agrees to participate by:

Client will practice problem-solving skills with therapist and then apply them at home/work.

Family Involvement: ☐ Biological ☐ Other (If other, please specify below)

Family is available

☐ Yes ☒ No

Client consents to family participation?

☐ Yes ☒ No ☐ N/A

Family agrees to participate?

☐ Yes ☒ No (If yes, please specify)

Outcomes: To be completed either when the objective is obtained or prior to the beginning of the next cycle month. If not met, please specify what was or was not met and adjust objective accordingly.

Initials:

Date:

Short-term Goals / Objectives:

Objective # 2

Effective Date: 4/20/12

To diminish anxious symptoms by increasing the use of healthy anxiety-reducing techniques or coping skills from 0x to 3x per week.

Clinical Interventions:

Type of Service: ☒ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other

Assist the client in re-engaging in physical activities that have helped to reduce anxiety in the past and learning new ways of dealing with distress

Client Involvement

Client agrees to participate by:

Client will go to the gym and listen to soothing music.

Family Involvement: ☐ Biological ☐ Other (If other, please specify below)

Family is available

☐ Yes ☒ No

Client consents to family participation?

☐ Yes ☒ No ☐ N/A

Family agrees to participate?

☐ Yes ☒ No (If yes, please specify)

Outcomes:

Initials:

Date:

Additional Client Contacts/Relationships: Refer to the "MH 525: Contact Information" form.

☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds
☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run/NAMI
☐ Education/AB 3632 ☐ Other

Interpretation

Prefer a language other than English: ☐ Yes ☒ No

This plan was interpreted: ☐ Yes ☒ No

Language:

*MHS includes therapy/rehab (individual, family, or group), psychological testing, collateral and team conference/consultation services.

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Name: XXXXX

ID#: XXXXX

Agency: XXXX

Provider #: XXXX

Los Angeles County - Department of Mental Health

Client Care Page of the CLIENT CARE/COORDINATION PLAN

CLIENT CARE COORDINATION PLAN

Annual Cycle Month: (Due prior to the 1st day of the Month)
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Client Long Term Goals: (use client direct quote)

"I want to get emotional support and talk about my problems"

Short-term Goals / Objectives: Must be SMART: Specific, Measurable/Quantifiable, Attainable within this year, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1

Effective Date: 4/20/12

To increase # of social interactions from 0x to 3x per week.

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: ☒ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other

Engaging the client in "behavioral activation" in order to reduce depressed mood by gradually increasing engagement in pleasant and enjoyable activities.

Client Involvement

Client agrees to participate by:

Client will engage in pleasant activities at home and report back to therapist his/her successes/difficulties and feelings about the experience.

Family Involvement: ☐ Biological ☐ Other (If other, please specify below)

Family is available

☒ Yes ☐ No

Client consents to family participation?

☒ Yes ☐ No ☐ N/A

Family agrees to participate?

☐ Yes ☒ No (If yes, please specify)
Outcomes: To be completed either when the objective is obtained or prior to the beginning of the next cycle month. If not met, please specify what was or was not met and adjust objective accordingly.

Initials:

Date:

Short-term Goals / Objectives:

Objective # 2

Effective Date: 4/20/12

Decrease client's depression and helpless feelings as evidenced by client's PHQ-9 scores decreasing from 17 to 2.

Clinical Interventions:

Type of Service: ☒ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other

Teaching and reinforcing active problem-solving skills in order to increase client's self-efficacy and improve his mood.

Client Involvement

Client agrees to participate by:

Attending PST sessions and completing required homework.

Family Involvement: ☐ Biological ☐ Other (If other, please specify below)

Family is available

☐ Yes ☒ No

Client consents to family participation?

☐ Yes ☒ No ☐ N/A

Family agrees to participate?

☐ Yes ☒ No (If yes, please specify)

Outcomes:

Initials:

Date:

Additional Client Contacts/Relationships: Refer to the "MH 525: Contact Information" form.

Interpretation

☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds
☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run/NAMI
☐ Education/AB 3632 ☐ Other
Prefer a language other than English: ☐ Yes ☒ NoThis plan was interpreted: ☐ Yes ☒ No

Language:

MHS includes therapy/rehab (individual, family, or group), psychological testing, collateral and team conference/consultation services.

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Name: XXXXX

IS#: XXXXX

Agency: XXXX

Provider #: XXXX

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PROGRESS NOTE

Date: <u>4/18/12</u>	Telephone Contact: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N	Rendering Provider Face-to-Face/Other Time* (Hrs:Mins): <u>:30/0:00</u>
Procedure Code: <u>90806</u>	Other Staff Initials: _____	Total Time* (Hrs:Mins): _____
* All travel and documentation time must be recorded as "Other" or "Total Time"		
MHS Activity Type: <input type="checkbox"/> Assessment <input checked="" type="checkbox"/> Ind Tx <input type="checkbox"/> Ind Reh <input type="checkbox"/> Col <input type="checkbox"/> PsyT <input type="checkbox"/> Team Conf/CaseCon	Other Staff Initials: _____	Total Time* (Hrs:Mins): _____
<input type="checkbox"/> GrpTx <input type="checkbox"/> GrpReh # of Clients Represented: _____	Other Activity Type: <input type="checkbox"/> Cris Int <input type="checkbox"/> TCM	

Client was seen for his last session. Client appeared well groomed and was casually dressed. His affect appeared euthymic. Client stated feeling happier and not as lonely as before. Client had mentioned that he had worked through other problems he had alone by using PST. Client stated that he joined a Cancer support group which he feels really good about and has made new friends. We reviewed clients progress and clinician administered PHQ-9 to client. Client's score on PHQ-9 was a 2. Clinician praised clients efforts and success in treatment. Clinician helped client identify early warning signs of relapse, reviewed skills learned during therapy, and developed a relapse prevention plan for managing challenges. Client thanked clinician for his help. Completed required documentation and closed case.

☐ Continued (Sign & complete claim information on last page of note.)

Signature & Discipline _____

Date _____

Co-signature & Discipline _____

Date _____

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Name _____

IS#: _____

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PROGRESS NOTE